

**HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND**

**P.O. BOX 2121  
HONOLULU, HI 96805  
EFFECTIVE JANUARY 1, 2009**

**1A HMO MEDICAL/PRESCRIPTION DRUG Kaiser**

- |                           |                          |            |
|---------------------------|--------------------------|------------|
| A. Non-Medicare - Self    | <input type="checkbox"/> | \$470.00   |
| B. Non-Medicare - 2-Party | <input type="checkbox"/> | \$916.86   |
| C. Non-Medicare - Family  | <input type="checkbox"/> | \$1,358.72 |
|                           |                          |            |
| D. Medicare - Self        | <input type="checkbox"/> | \$232.08   |
| E. Medicare - 2-Party     | <input type="checkbox"/> | \$452.94   |
| F. Medicare - Family      | <input type="checkbox"/> | \$671.12   |

Select one plan and enter premium amount (go to line 2)

**1A** \$ \_\_\_\_\_

**1B PPO MEDICAL HMA HMSA**

- |                           |                          |          |                          |          |
|---------------------------|--------------------------|----------|--------------------------|----------|
| A. Non-Medicare - Self    | <input type="checkbox"/> | \$281.80 | <input type="checkbox"/> | \$290.38 |
| B. Non-Medicare - 2-Party | <input type="checkbox"/> | \$549.14 | <input type="checkbox"/> | \$565.88 |
| C. Non-Medicare - Family  | <input type="checkbox"/> | \$814.10 | <input type="checkbox"/> | \$838.92 |
|                           |                          |          |                          |          |
| D. Medicare - Self        | <input type="checkbox"/> | \$116.30 | <input type="checkbox"/> | \$121.90 |
| E. Medicare - 2-Party     | <input type="checkbox"/> | \$226.76 | <input type="checkbox"/> | \$237.70 |
| F. Medicare - Family      | <input type="checkbox"/> | \$336.16 | <input type="checkbox"/> | \$352.36 |

Select one plan and enter premium amount

If you selected a plan in 1A, Kaiser, you cannot select an option from this section.

**1B** \$ \_\_\_\_\_

**1C PRESCRIPTION DRUG NMHC**

- |                           |                          |          |
|---------------------------|--------------------------|----------|
| A. Non-Medicare - Self    | <input type="checkbox"/> | \$122.04 |
| B. Non-Medicare - 2-Party | <input type="checkbox"/> | \$237.78 |
| C. Non-Medicare - Family  | <input type="checkbox"/> | \$352.50 |
|                           |                          |          |
| D. Medicare - Self        | <input type="checkbox"/> | \$168.00 |
| E. Medicare - 2-Party     | <input type="checkbox"/> | \$327.22 |
| F. Medicare - Family      | <input type="checkbox"/> | \$485.12 |

Select one plan and enter premium amount

If you selected a plan in 1A, Kaiser, you cannot select an option from this section.

**1C** \$ \_\_\_\_\_

**2 DENTAL HDS**

- |                       |                          |         |
|-----------------------|--------------------------|---------|
| Non Medicare/Medicare |                          |         |
| Self                  | <input type="checkbox"/> | \$30.18 |
| 2-Party               | <input type="checkbox"/> | \$58.98 |
| Family                | <input type="checkbox"/> | \$72.22 |

Select one plan and enter premium amount

**2** \$ \_\_\_\_\_

**3 VISION VSP**

- |                       |                          |         |
|-----------------------|--------------------------|---------|
| Non Medicare/Medicare |                          |         |
| Self                  | <input type="checkbox"/> | \$4.42  |
| 2-Party               | <input type="checkbox"/> | \$8.84  |
| Family                | <input type="checkbox"/> | \$11.88 |

Select one plan and enter premium amount

**3** \$ \_\_\_\_\_

**4** Add lines 1A or 1B and 1C, 2, 3 (Medical, Prescription Drug, Dental, Vision)

**4** \$ \_\_\_\_\_

**5 EMPLOYER CONTRIBUTION 0% 50% 75%**

- |                           |                          |        |                          |          |                          |            |
|---------------------------|--------------------------|--------|--------------------------|----------|--------------------------|------------|
| A. Non Medicare - Self    | <input type="checkbox"/> | \$0.00 | <input type="checkbox"/> | \$322.42 | <input type="checkbox"/> | \$483.62   |
| B. Non Medicare - 2-Party | <input type="checkbox"/> | \$0.00 | <input type="checkbox"/> | \$649.88 | <input type="checkbox"/> | \$974.82   |
| C. Non Medicare - Family  | <input type="checkbox"/> | \$0.00 | <input type="checkbox"/> | \$951.18 | <input type="checkbox"/> | \$1,426.76 |
|                           |                          |        |                          |          |                          |            |
| D. Medicare - Self        | <input type="checkbox"/> | \$0.00 | <input type="checkbox"/> | \$229.68 | <input type="checkbox"/> | \$344.52   |
| E. Medicare - 2-Party     | <input type="checkbox"/> | \$0.00 | <input type="checkbox"/> | \$460.34 | <input type="checkbox"/> | \$690.50   |
| F. Medicare - Family      | <input type="checkbox"/> | \$0.00 | <input type="checkbox"/> | \$670.48 | <input type="checkbox"/> | \$1,005.72 |

Check your medical selection on line 1A or 1B or your prescription drug selection on line 1C.

(For example, if you selected 1AA, your employer contribution will be non medicare self.)

Enter your employer contribution amount (0% or 50% or 75%).

**5** \$ \_\_\_\_\_

**6** Line 4 minus line 5, enter the AMOUNT YOU OWE monthly

**6** \$ \_\_\_\_\_

If line 5 is greater than line 4, you do not owe any premiums

**Please keep this sheet for your records. We do not send monthly billings or statements. Your monthly amounts will be on your confirmation notice. Payments are due by the first of the month, you may pay for more than one month of premiums on one check. Please make checks payable to EUTF.**